circulating numbers of CD34+ cells was a better predictor of successful mobilization than WBC. Our observation that 3/3 patients who had 5-10 CD34+ cells/ul were also successfully collected suggests that it may be possible to lower the start of collection to when the CD34+ count is >5/ul.

495

HEART SUCCESS WITH BLOOD AND MARROW TRANSPLANT PATIENTS: A MULTIDISCIPLINARY APPROACH FOR CONGESTIVE HEART FAILURE PATIENTS

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By 2010, it is estimated that the American population aged 65 or older will increase to over 40 million individuals. This will result in an increase in the average age of the Blood and Marrow Transplant population. Increased age translates into co- morbid conditions that contribute to a significant proportion of morbidity and mortality. One example of this includes cardiovascular conditions that patients bring with them at an increasing rate as they advance in age. The average rates of cardiovascular events rise from 7 per 1000 men ages 35-44 to 68 per 1000 men ages 85-94 with narrowing gaps with advancing age, and comparable rates occur 10 years later in life for women. Congestive heart failure (CHF) is one of those cardiovascular co-morbid conditions that this patient population continues to bring into the transplant setting or is developed as a result of treatment. CHF affects 1.5-2% of the population and increases 6-10% in people greater than 65 years of age. In 2003, more than 400 patients were hospitalized at the comprehensive cancer center with a discharge diagnosis of CHF totaling a cost of 36 million dollars. Cancer patients with heart failure can have improved clinical outcomes. To improve clinical outcomes of these patients, we have teamed together with Cardiology and have implemented a Heart Success Program on the 52-bed inpatient unit. The program entails education of the staff and patients about the symptoms of CHF, the importance of daily weights, medications, walking, energy conservation, and nutrition. The program is a multidisciplinary approach including Pharmacy, APNs, Nursing, Rehabilitation Services, Social work, Case Management, and Nutrition. The goals for the staff utilizing the heart success program include increasing nurses' awareness of the pathophysiology and pharmacology of CHF, being more proactive in its recognition, and identifying patients eligible for the program. The overall goals are to have a reduction in hospital admissions for heart failure exacerbation, decrease the length of stay and healthcare dollars spent. Weekly rounds are conducted with Cardiology to review the CHF patients. A case will be presented.

496

CLINICAL NURSE RESOURCE: A NEW ROLE DESIGNED TO SUPPLEMENT VACANT CLINICAL NURSE SPECIALIST POSITIONS

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Clinical Nurse Specialists (CNS) perform a critical role in leading efforts to improve outcomes affecting the oncology patient. Through direct intervention, promotion of clinical assessment skills, critical thinking, advanced clinical skills, and knowledge, and interactions with the interdisciplinary team, the CNS works to advance oncology nursing practice as direct care providers, consultants, educators, patient, and system advocates, team coordinators, program designers, and/or researchers. With the downsizing of the CNS role in hospital and institutional settings, this has led to a steady decline in the number of applicants entering CNS academic programs. As a result, institutions that value the CNS role, and the expertise they provide in highly complex patient care environments, have experienced long-standing vacancies. Due to the inability to fill two vacant CNS positions on the Blood and Marrow Transplant Unit (BMT), a method was undertaken to identify and recognize experienced clinical nurses who could practice as unit resources and contribute to the mentoring, support, and development of patient care providers and evidence-based quality indicators on the inpatient unit. The Clinical Nurse Resource (CNR) position was developed to address this need. A position description including essential functions in clinical practice, education, collaboration/consultation, research/quality improvement, and leadership was formulated. Performance criteria in clinical practice included serving as a clinical expert in BMT and promoting excellence in clinical nursing practice through assessment and interaction with staff and the interdisciplinary team. Education incorporated providing educational opportunities to develop and enhance performance, problem-solving, and critical thinking. Collaboration/consultation involved collaborating and consulting with the interdisciplinary team to improve patient care delivery. Research included the identification and participation in researchable patient problems or clinical inquiry projects. Outcomes of the CNR positions were documented on a developed evaluation tool. Value of the CNR position was immediately achieved with significant positive outcomes. Some of these included mentorship/coaching of new BMT clinical staff and an evidence-based research project to reduce the incidence of falls on the unit. The CNR position on the inpatient BMT unit has proven to be beneficial as an alternative to fulfill the desired role of the CNS.

497

UNMASK THE PEDIATRIC ALLOGENEIC TRANSPLANT PATIENT: A SINGLE CENTER'S EXPERIENCE ON THE USE OF FLUCONAZOLE FOR ANTIFUNGAL PROPHYLAXIS IN PATIENTS NOT USING FACE MASKS POST TRANSPLANT

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Many transplant centers require pediatric hematopoietic allogeneic transplant patients to wear a face mask until day +100 or longer. Unlike most transplant centers, our allogeneic recipients are not required to wear a face mask post-transplant. Our experience indicates that with the use of fluconazole as standard antifungal prophylaxis it is not necessary to require our patients to wear face masks post-transplant. Fluconazole (Diflucan) dosed at 3-5 mg/kg daily is started on the day of admission pre-transplant and discontinued once ANC > 500 times 3 days (engraftment). Patients with graft-versus-host disease (GVHD) continue to receive antifungal prophylaxis with fluconazole while on immunosuppressive therapy. We conducted a retrospective chart review of 22 pediatric allogeneic hematopoietic cell transplant (HCT) patients from 1999-2004, which revealed no reported occurrences of fungal infections. The patients were treated prophylactically with Diflucan. Four patients were changed to Ambisome due to recurrent fevers with negative cultures, and 1 was changed due to interaction between Diflucan and Tacrolimus. Patients were not required to wear a face mask post-transplant. Therefore, we can speculate that not wearing a mask does not increase the risk of fungal infections in pediatric allogeneic HCT. Cases need to be evaluated on an individual basis, including risk factors and conditioning regimens. We advocate for larger studies to be completed regarding this topic.

498

THE BLOOD AND MARROW TRANSPLANTATION BUSINESS CENTER THAT MAKES A DIFFERENCE IN THE PROCESSING OF BMT PATIENTS

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The complexity of the Blood and Marrow Transplantation (BMT) financial process is usually a challenging hurdle for patients during their treatment. At one of the largest transplant centers in the country, a multidisciplinary team has developed a process that enables patients to navigate this aspect of their treatment with ease. The BMT Business Center (BC) was created to secure authorization for transplantation from insurance companies. The financial process covers referrals and consultation from point of access to admission. To accomplish this, each BC team member has expertise in their role and is accountable for their portion of the process. The BC is composed of a Patient Access Supervisor, a Patient Access Appeals/Denials Coordinator (PADAC), and 4